

Compelled Drug Addiction Treatment Works Because of Retention

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There is little question that civil commitment saves lives of severely addicted people in the short term by abruptly interrupting cycles of extreme self-destruction. This acute rescue function is not enough, however.

While everyone prefers that patients voluntarily get help instead of being forced into it, the rate of drop-out from voluntary commitment after several weeks is a [common problem](#). Drop out almost always means relapse. Civil commitment – with patients’ legal right to challenge, of course – provides the leverage to remain in care.

But can treatment work if it is compelled? Yes. There is [ample evidence](#) that it is at least as effective, and sometimes more effective, than voluntary care. Again, the reason is retention: The longer one stays in treatment, the more time spent toward managing cravings and other negative states; repairing family relationships and starting new, healthier networks; finding new modes of fulfillment; and developing realistic future plans.

Importantly, after initial stabilization and detox, treatment need not take place in an institution. Structured supervision, ideally [supplemented](#) with [incentives for clean drug tests](#) and [immediate consequences](#), boasts a promising track record. For opiate dependence, opioid-receptor blockers such as naltrexone or replacement medications such as buprenorphine can reduce craving considerably.

Both the public and physicians generally endorse involuntary care and containment for psychotic people who can’t care for themselves or pose a danger to others. The same for suicidal individuals.

But what about a patient just revived from overdose with Narcan (which instantly reverses opiate overdose)? If this person walks out the emergency room door – as is common -- it’s almost guaranteed he or she will hunt for more drugs. To a physician, it can feel like abandonment to sign the patient out or discharge against medical advice.

Severely addicted people are not delusional and, thus, not intrinsically beyond reason. Nor are they fully autonomous. One hopes a physician-initiated three-day hold, of the kind Massachusetts Governor Baker is proposing, would provide a respite (paired with a signal to the patient of the gravity of the situation) during which he or she ends up agreeing to long-term care. Coercion should be an option of last resort for those at grave risk.

But if help is still refused and the individual is therefore mandated to monitored quality treatment, over time he or she often becomes open to change.